PRINTED: 09/15/2011

	I OF HEALTH AND HUN R MEDICARE & MEDIC						IB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/10/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8400 NORTHWEST BLVD INDIANAPOLIS, IN46278				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PERCEDED BY FULL SELSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
S0000		or a standard licensure : 003930 8/10-11 MHA or urse Surveyor	S0	000			
S0178	posted on the hos area open to patie	(a) all be conspicuously spital premises in an ents and public. A spicuously posted in					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on observation, the hospital failed

an area open to patients and public on the premises of each separate hospital

building of a multiple hospital

building system.

TITLE

The license at the Greenwood

(X6) DATE

08/15/2011

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C97011

S0178

Facility ID:

003930

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160	(X2) MULTIPI A. BUILDING B. WING		00	(X3) DATE : COMPL 08/10/2	ETED
	ROVIDER OR SUPPLIER		840	00 NO	DDRESS, CITY, STATE, ZIP CODE PRTHWEST BLVD POLIS, IN46278		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
		post the hospital license patients and the public			offsite was moved to an area is more open to patients. The was completed on 8/15/2011 Annette Nelson and confirme Jane Keller on 8/20/2011	e by	
S0312	of employee #A3 Greenwood offsi license was not p	10:45 am in the presence s, it was observed in the te that the hospital's osted conspicuously in atients and the public.					
30312	(c) The governing for managing the h governing board s following: (6) Require that th	board is responsible nospital. The hall do the					
	based on a job de employee providin or support services	g direct patient care s, including cy personnel, who are					
	the facility failed policy, a perform 11 employee file	ent review and interview, to conduct, per facility ance evaluation for 5 of s reviewed.	S0312		Effectively immediately, an authorized hospital employed review all performance evaluations conducted by the contracted company. The director of HR will be respons for making sure that this occur	e sible	09/12/2011
	Findings: 1. Review of 15	personnel files indicated			and random audits will be conducted to make sure that is occurring as per policy.		

PRINTED: 09/15/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	li i	TE SURVEY IPLETED 1/2011
	PROVIDER OR SUPPLIER		STRI 840	EET ADDRESS, CITY, STAT O NORTHWEST BLV IANAPOLIS, IN46278	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR contracted emplo	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) byee files PF#10, PF#11,	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	contain any docu performance eva itself nor any doc an authorized hos evaluation condu	luation by the facility cumentation of review by spital employee of the acted by the contractor.				
	requested to providocumentation and prior to exit.	nd none was provided				
	provide documer policy on perform employee indicat	11:55 am, upon yee #A1 was requested to ntation of the facility's nance evaluation. The red the policy was as employee handbook.				
	entitled PERFOR EVALUATION,	ection in the handbook RMANCE indicated performance enerally performed on an				

003930

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160		A. BUILDING	G	00	(X3) DATE S COMPL 08/10/2	ETED	
	PROVIDER OR SUPPLIER		84	00 NO	DDRESS, CITY, STATE, ZIP CODE PRTHWEST BLVD APOLIS, IN46278		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
S0318	for managing the governing board stollowing: (6) Require that the officer develops provide direct pating carding contract provide direct pating assed on document the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers, who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers who provide direct pating the hospital faile cardiopulmonary competence in a standards of practice workers who provide direct pating the hospital faile cardiopulmonary competence in	board is responsible nospital. The hall do the le chief executive policies and programs opulmonary R) competence in urrent standards of practice of for all health care workers, and agency personnel, who ent care. The entire workers are used to ensure of resuscitation (CPR) decordance with current effice for health care povide direct patient care.	S0318		Beginning immediately, all he care workers, including contracted and agency personal will have proof of CPR competence in their employer files. If this is not obtained in timely manner, then the emp will not be scheduled to work proof is available. The direct HR will make sure this is accomplished and the safety manager will conduct random audits to make sure facility is compliance.	onnel ee loyee cuntil tor of	09/12/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		150160	B. WING		08/10/2	011
	PROVIDER OR SUPPLIER		840	EET ADDRESS, CITY, STATE, ZIP CODE 0 NORTHWEST BLVD IANAPOLIS, IN46278	•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
S0330	410 IAC 15-1.4-1(c)(6)(K)				
	(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (K) Maintaining personnel records for					
			S0330	Beginning immediately we begin the process of gettindocumentation into the perfiles so they include documentation of proper immunizations, TB tests and B status. The director of H be responsible for making that this is completed. The manager will conduct randaudits to make sure facility compliance.	g all sonnel d Hep R will sure safety	10/10/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 150160		A. BUILDING	E CONSTRUCTION 00	COM	TE SURVEY IPLETED 1/2011	
	PROVIDER OR SUPPLIER		8400	ET ADDRESS, CITY, STATE, Z O NORTHWEST BLVD IANAPOLIS, IN46278	IP CODE	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	CROSS-REFERENCED TO	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION
TAG	proof of vaccinate titer. Those who Varicella must be 2. Review of 11 files PF#7, PF#8 any documentation history to Rubell 3. Review of hos 77017, entitled Eindicated employ occupational expethe average of or monthly and who documentation of the vaccine series of prior disease, vaccine. Further personnel who we B vaccine and dedocumentation eindicating their ce 4. Review of 11 files PF#10 and 1 potential for occupations B on the times per monthly have documentation.	ion must have a Varicella are seronegative for avaccinated. personnel files indicated and PF#10 did not have on of immunization a and Varicella. pital PolicyStat ID: imployee Vaccination, rees with the potential for osure to Hepatitis B on it or more times per o do not have in history of completion of its or laboratory evidence should obtain this review indicated ere offered the Hepatitis cline have intered into their record hoice. personnel files indicates PF#11, both had the inpational exposure to e average of one or more y. They both also did not ion or history of	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
	laboratory evider Further review in	e vaccine series or nce of prior disease. dicated these 2 personnel ration of declining to be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/10/2011
	PROVIDER OR SUPPLIER		STREET A 8400 N	ADDRESS, CITY, STATE, ZIP CODE ORTHWEST BLVD IAPOLIS, IN46278	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	offered the Hepa	titis B vaccine.	TAG	DEFICIENCY)	DATE
	77017, entitled E indicated all emphave a TB [tuber	spital PolicyStat ID: imployee Vaccination, iloyees are required to culosis] screening within cemployment and er.			
	files PF#1, PF#1	personnel files indicated 0 and PF#11 did not have on of a current annual TB			
	employee #A6 ar employee # A1 v	on 8-8-11 at 3:30 pm, and on 8-10-11 at 3:15 pm, were requested to provide entation and none was			
S1020	410 IAC 15-1.5-7 (d) Written policies shall be developed that include the following the state of	and procedures d and implemented			
		ugs and biologicals ich address, but are			
	(A) Separation of of external use from internal use. Based on documents		S1020	Effectively immediately, the physical therapy department	s will 09/12/2011

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/10/2011
	PROVIDER OR SUPPLIER		8400 N	ADDRESS, CITY, STATE, ZIP CODE ORTHWEST BLVD IAPOLIS, IN46278	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	inspection of 3 a stored. Findings: 1. Review of ho 7492, entitled Qu Storage Areas - 1 indicated all med shall be inspecte with proper storatevery month, instead documented and is responsible for reports. 2. On 8-9-11 at of employees #A interview, employees the interview, employers with the medication demployee was as documentation of checks in those at the employee indication.	the pharmacist manager reviewing the inspection 10:10 am in the presence 4 and #A5, upon yee #A7, indicated 3 reatment areas were examethasone. This		conduct monthly pharmacy checks and submit those checks are submit those checks and submit those check	or sical for

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160	A. BUILDING B. WING	00	— COMI 08/10/	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIEI A ORTHOPAEDIC H		8400 N	ADDRESS, CITY, STATE, ZIP CO ORTHWEST BLVD JAPOLIS, IN46278	ODE	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
S1118	(b) The condition plant and the ove environment shall maintained in such safety and well-be assured as follow (2) No condition maintained which hazard to patients employees. Based on observents ensure no condition maintained which to patients, publication (1) instance. Findings: 2. On 8-9-11 at of employees #4 observed in the Radiology area, alcohol-based har affixed to a wall electrical outlet. 3. The location located directly source, posed a flammable alcohol-based affixed to a condition of the content of	of the physical rall hospital I be developed and the amanner that the eing of patients are s: shall be created or may result in a se, public, or ration, the facility failed to the tion was created or the may result in a hazard ic, or employees in one 10:30 am in the presence A4 and #A5, it was Clean Supply Room in the there was an and sanitizer (ABHS) directly above an of the ABHS, being over an electrical ignition	S1118	The ABHS was move location on the wall s not above the electric receptacle. This was by the facility manage confirmed by the safe	so that it is cal s completed er and	08/15/2011

					1		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED	
		150160			08/10/2	011	
			B. WING	A DDDDEGG CKEY CEARE GIR CODE			
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE			
			8400 NORTHWEST BLVD				
INDIANA	ORTHOPAEDIC H	OSPITAL LLC	INDIAN	NAPOLIS, IN46278			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROVIDENIC N. AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE	
S1150	410 IAC 15-1.5-8	·					
31130	110 1/10 10 1:0 0	(5)(5)					
	(c) In new constru	iction, renovations					
	and additions, the						
	facilities, or nonlicensed facilities acquired for the purpose of providing						
	hospital services,						
	following:	Shall meet the					
	(9) All back flow prevention devices						
		as required by 327					
	IAC 8-10 and the						
		oing code. Such devices					
	shall be listed as	· ·					
	department.	approved by the					
	•		01150	A vacuum breaker type back	kflovy	00/17/2011	
		ration, the hospital failed	S1150	prevention device was insta		08/15/2011	
	to a install backf	flow prevention device as		on the spigot in this area. T			
	required by 327	IAC 8-10 and the current		work was completed by the			
	addition of the I	ndiana plumbing code in		manager and confirmed by the			
	1 instance.	nama pramong to at m		safety manager.	uic		
	i ilistance.			Salety manager.			
	Findings:						
	1. On 8-9-11 at	10:50 am in the presence					
		A4 and #A5, it was					
		Environmental Services					
	closet there was	a flexible hose connected					
	to a water spigot	and there was no					
	backflow preventor.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C97011

003930

Facility ID:

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150160		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		•	8400 N	ADDRESS, CITY, STATE, ZIP CODE ORTHWEST BLVD APOLIS, IN46278		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
S1160	follows: (1) All equipment working order and maintained. Based on docum failed to follow trecommendation of 1 defibrillator Findings: 1. Review of the Operator's Guide document entitle R Series Product indicated recomprocedures to be included, but we checking, the own defibrillator, Har electrodes, Paddicracks, broken w Fully charged sp checking Dispos 2. Review of he 85122, entitled E Cart And Critical the contents of the functioning of critical and maintain and m	shall be in good regularly serviced ent review, the facility he manufacturer's for weekly maintenance e ZOLL R Series indicated there was a d Operator's Checklist for This document mended checks and performed weekly. They are not limited to erall condition of the inds-free Therapy les, Inspect cables for irres, connector, Batteries are battery available, and	S1	160	Effectively immediately all departments will follow the manufacturer's recommendator weekly maintenance of the defibrillator. The facility check will be revised to encompass aspects as listed by the manufacturer. The education coordinator will be responsible completing this task and the safety manager will do rando audits to ensure compliance.	ne eklist s all n ole for	09/12/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 150160		A. BUIL B. WING	DING	00	(X3) DATE S COMPL 08/10/20	ETED	
	ROVIDER OR SUPPLIER			8400 NC	DDRESS, CITY, STATE, ZIP CODE DRTHWEST BLVD APOLIS, 1N46278		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	1 2	licated to record results checklist (attached).					
	2011, provided b indicated it did n weekly checks as Operator's Check 4. On 8-10-11 arrequested to provide weekly checks are	CHECK LOG for August, y employee #A4, ot document the above indicated in the clist for R Series Product. m, employee #A4 was ride documentation of					
S1164	410 IAC 15-1.5-8(d) The equipment follows: (2) There shall be equipment and spisafe, effective, and of the available se as follows: (B) There shall be preventive mainter	requirements are as sufficient ace to assure the ditimely provision rvices to patients,					
	equipment.	ew, the hospital failed to of preventive	S1:	164	Effective immediately, all equipment will have PM's on them. The unit in question, the Sonoline G-4, has had the Pl	he	09/12/2011

NAME OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPICIENCIES SUMMARY STATEMENT OF DEPICEMENT OF DEPICEME			IDENTIFICATION NUMBER:	A. BUILDING O			COMPLETED 08/10/2011		
NAME OF PROVIDER OR SUPPLIER INDIANA ORTHOPAEDIC HOSPITAL LLC INDIANAPOLIS, IN46278 (X4) ID PREFIX TAG Equipment equipment Findings: 1. On 8-9-11 at 10:20 am, hospital staff was requested to provide documentation of PM on a piece of ultrasound equipment, a Sonoline G-4. The staff indicated there was no PM performed on the machine and no documentation was STREET ADDRESS, CITY, STATE, ZIP CODE 8400 NORTHWEST BLVD INDIANAPOLIS, IN46278 STREET ADDRESS, CITY, STATE, ZIP CODE 8400 NORTHWEST BLVD INDIANAPOLIS, IN46278 ID PREFIX TAG COMPLETION CASH PREFIX TAG COMPLETION CASH CASH PREFIX TAG CASH PREFIX TAG COMPLETION CASH CASH PREFIX TAG COMPLETION CASH CASH PREFIX TAG CASH PREFIX TAG COMPLETION CASH CASH PREFIX TAG CASH PREFIX TAG COMPLETION CASH CASH PREFIX TAG CASH PREF									
INDIANA ORTHOPAEDIC HOSPITAL LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) equipment indicated there was no PM performed on the machine and no documentation was 8400 NORTHWEST BLVD INDIANAPOLIS, IN46278 8400 NORTHWEST BLVD INDIANAPOLIS, IN46278 ID PROVIDERS PLAN OF CORRECTION (X5) (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE Completed on it and this particular piece of equipment has been added to our equipment list so that it is not overlooked in the future. The manager of materials will be responsible for compliance and the safety manager will conduct random audits to make sure equipment is not overlooked.	100100				B. WING				
INDIANA ORTHOPAEDIC HOSPITAL LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Findings: 1. On 8-9-11 at 10:20 am, hospital staff was requested to provide documentation of PM on a piece of ultrasound equipment, a Sonoline G-4. The staff indicated there was no PM performed on the machine and no documentation was INDIANAPOLIS, IN46278 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE Completed on it and this particular piece of equipment has been added to our equipment list so that it is not overlooked in the future. The manager of materials will be responsible for compliance and the safety manager will conduct random audits to make sure equipment is not overlooked.	NAME OF P	ROVIDER OR SUPPLIER	L Comments						
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH DEFICIENCY) MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION DATE COMPLETION COMPLETION DATE COMPLETION									
rag regulatory or LSC IDENTIFYING INFORMATION) equipment equipment Findings: 1. On 8-9-11 at 10:20 am, hospital staff was requested to provide documentation of PM on a piece of ultrasound equipment, a Sonoline G-4. The staff indicated there was no PM performed on the machine and no documentation was CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETED COMPLETED CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETED PLATE COMPLETED						PROVIDER'S PLAN OF CORRECTION			
equipment Findings: Completed on it and this particular piece of equipment has been added to our equipment list so that it is not overlooked in the future. The manager of materials will be responsible for compliance and the safety manager will conduct random audits to make sure equipment, a Sonoline G-4. The staff indicated there was no PM performed on the machine and no documentation was		1				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤE		
Findings: Findings: Diece of equipment has been added to our equipment list so that it is not overlooked in the future. The manager of materials will be responsible for compliance and the safety manager will conduct random audits to make sure equipment, a Sonoline G-4. The staff indicated there was no PM performed on the machine and no documentation was	IAG	· · · · · · · · · · · · · · · · · · ·			IAG			DATE	
		Findings: 1. On 8-9-11 at was requested to of PM on a piece equipment, a Sor indicated there we the machine and	provide documentation e of ultrasound noline G-4. The staff vas no PM performed on no documentation was			piece of equipment has beer added to our equipment list state that it is not overlooked in the future. The manager of mate will be responsible for compland the safety manager will conduct random audits to materials.	n so e erials iance		